

The Health Plan: PEIA PLAN A

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7-1-15 to 6-30-16

Coverage for: **Single or Family** | Plan Type: **HMO**



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by email at info@healthplan.org or by calling 740.695.7902 or 1.888.847.7902, TDD 740.695.7919 or 1.800.622.3925.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$200 Single/ \$400 Family Doesn't apply to E.R. visits, preventive or urgent care, office visits (or any riders elected by employer).	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$3,600 Single/ \$7,200 Family RX: \$3,000 Single/ \$6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See healthplan.org or call 1.888.847.7902 for a list of participating providers.	If you use an In-Network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your In-Network doctor or hospital may use an Out-of-Network provider for some services. Plans use the term In-Network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . Written or oral approval may be required. Should you have questions call 740.695.7902 or 1.888.847.7902, TDD

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Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. **Non-participating providers require preauthorization.**

Common Medical Event	Services You May Need	Your cost if you use a	
		Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay/visit	-----None-----
	Specialist visit	\$40 copay/visit	Preauthorization may be required
	Other practitioner office visit	\$40 copay/visit	Audiology, Podiatry & Chiropractor require preauthorization, Chiropractor limited to 20 visits per contract year
	Preventive care/screening/immunization	No Charge	Must meet preventive guidelines
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	-----None-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Preauthorization may be required

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		Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthplan.org .	Generic drugs	\$10 copay/each retail, \$20 copay/each home delivery	Covers up to a 31-day supply retail, 90-day supply home delivery
	Preferred brand drugs	50% coinsurance/each retail, 50% coinsurance/each home delivery	Covers up to a 31-day supply retail, 90-day supply home delivery, member responsible for cost difference between generic and preferred brand
	Non-preferred brand drugs	Not Covered	-----None-----
	Specialty drugs	30% or \$300 coinsurance or copay whichever is less/each	Covers up to 30-day supply retail or home delivery, preauthorization required, covered under prescription benefit only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay + 15% coinsurance	Preauthorization may be required
	Physician/surgeon fees	\$100 copay + 15% coinsurance	Preauthorization may be required
If you need immediate medical attention	Emergency room services	\$100 copay/visit	True emergency services only
	Emergency medical transportation	\$50 copay/transport	Non-emergency transports require preauthorization
	Urgent care	\$50 copay/visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay + 15% coinsurance	Preauthorization required (unless emergent admission)
	Physician/surgeon fee	\$100 copay + 15% coinsurance	Preauthorization required (unless emergent admission)

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		Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$5 copay/visit	-----None-----
	Mental/Behavioral health inpatient services	\$100 copay + 15% coinsurance	Preauthorization required (unless emergent admission)
	Substance use disorder outpatient services	\$5 copay/visit	-----None-----
	Substance use disorder inpatient services	\$100 copay + 15% coinsurance	Preauthorization required (unless emergent admission)
If you are pregnant	Prenatal and postnatal care	\$40 copay/initial visit only	-----None-----
	Delivery and all inpatient services	\$100 copay + 15% coinsurance	-----None-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Services for intermittent skilled care only (home health aide not covered), preauthorization required
	Rehabilitation services	0% coinsurance days 1-30, 20% coinsurance days 31+	Preauthorization required
	Habilitation services	\$40 copay/visit per therapy type, 21+ visits 50% coinsurance	Requires preauthorization (e.g.: outpatient-physical, occupational and speech therapy)
	Skilled nursing care	\$35 copay/day	Limited to a maximum of 90 days per contract year and/or per qualifying diagnosis per lifetime
	Durable medical equipment	30% coinsurance	Equipment greater than \$500 requires preauthorization
	Hospice service	0% coinsurance	Preauthorization required
If your child needs dental or eye care	Eye exam	No Charge	Pediatric screening only (unless additional coverage elected by employer)
	Glasses	Not Covered	Unless vision rider elected by employer (see page 5)
	Dental check-up	No Charge	Pediatric screening only (unless additional coverage elected by employer)

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Most coverage provided outside the United States. See healthplan.org.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Prescriptions

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 740.695.3585 or 1.800.624.6961, TDD 740.695.7919 or 1.800.622.3925. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1.877.267.2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: The Health Plan Grievance Coordinator at 740.695.3585 or 1.800.624.6961, TDD 740.695.7919 or 1.800.622.3925.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,500
- Patient pays \$1,040

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$200
Copays	\$290
Coinsurance	\$500
Limits or exclusions	\$50
Total	\$1,040

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,450
- Patient pays \$1,950

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$200
Copays	\$260
Coinsurance	\$1,490
Limits or exclusions	\$0
Total	\$1,950

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.